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BALANCE QUESTIONNAIRE

Name:_____ Date:_____

Patients: In order to fully evaluate your complaints, please complete all questions and bring this survey with you when your return for your balance function testing.

1. Describe symptoms /complaints in detail:

2. When did symptoms begin:

3. How long do symptoms last (Circle answer):
   seconds minutes hours days

4. How often do symptoms occur (How many times per time):
   constant daily weekly monthly yearly

5. Symptoms occur when:
   walking standing sitting laying any time

Do you have:	No	Yes	Spells	Comments:
Imbalance / unsteadiness	__	__	____	_____
History of falling	__	__	____	_____
Spinning / tumbling	__	__	____	_____
Rocking / swaying	__	__	____	_____
Lightheadedness	__	__	____	_____
Fainting / Blacking Out	__	__	____	_____
Nausea / vomiting	__	__	____	_____
Double Vision	__	__	____	_____
Jumping Vision (while walking / riding)	__	__	____	_____

Are symptoms worsened by:

Lying down or rolling over	__	__	____	_____
Sitting or standing up	__	__	____	_____
Walking in darkness	__	__	____	_____
Walking on uneven surfaces	__	__	____	_____
Hot baths / showers	__	__	____	_____
Menstrual Cycle	__	__	____	_____
Exercise	__	__	____	_____
Reading / Computer Work	__	__	____	_____
Loud Noises	__	__	____	_____
Coughing, Sneezing, Straining	__	__	____	_____
Head turns while walking	__	__	____	_____

Ears / Eyes:	No	Right	Left
Hearing Loss	___	____	____
Fluctuating Hearing	___	____	____
Tinnitus (ringing, buzzing,etc.)	___	____	____
Frequent Ear infections	___	____	____
Perforated / Torn Eardrum	___	____	____
Ear Surgery	___	____	____
Ear Injuries	___	____	____
Eye Injury	___	____	____
Eye Surgery	___	____	____
Use of Eye Patch	___	____	____

Headache History

Headaches : No Yes

How often do they occur: daily weekly monthly

How long do they last? minutes hours days

Headache medications List:_____

Migraine :	Yes	No	
Since how Long? _____			
With nausea vomiting	yes	No	
Caused by certain food / drink	Yes	No	
Family history of migraine	Yes	No	
Related to menstrual cycle	Yes	No	N/A

Habits:

Alcohol :_____

Caffeine :_____

Tobacco: _____

Recreations Drugs :_____

Past Medical History: Please describe and list dates.

_____

_____

_____

_____

Motor Vehicle Accident:

Head Injury:

Chronic illness (e.g. diabetes, hypertension) requiring medication:

Intravenous antibiotics, chemotherapy, radiation therapy:

Medications: Please list

Please follow instructions carefully before coming for your Balance tests. Failure to do so will result in wrong diagnosis. Ensure that you have an accompanying driver to take you back home after the tests.

Lascelles Pinnock, MD **Rajashree Natarajan, AUD CCC-A**